STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001236	A. BLDG: 00 B. WING:	01/04/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ASSOCIATES SURGERY CENTERS, L.L.C. STATE LICENSE NUMBER: **50361501**	**9970 MOUNTAIN VIEW DRIVE SUITE 100 WEST MIFFLIN, PA 15122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
Q 0000	INITIAL COMMENT This report is the result of a revisit conducted on January 4, 2023, at Associates Surgery Centers L.L.C. as the result of a previous re-certification survey conducted on September 1, 2022. It was determined the facility was in compliance with the requirements of 42 CFR, Title 42, Part 416 - Conditions for Coverage for Ambulatory Surgical Centers.	Q 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001236	A. BLDG: 00 B. WING:	01/04/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ASSOCIATES SURGERY CENTERS, L.L.C. STATE LICENSE NUMBER: **50361501**	**9970 MOUNTAIN VIEW DRIVE SUITE 100 WEST MIFFLIN, PA 15122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 0000	INITIAL COMMENT This report is the result of an unannounced revisit survey conducted on January 4, 2023, following a State Licensure survey completed on September 1, 2022, at Associates Surgery Centers, L.L.C. It was determined that the facility was in compliance with the requirements of the Pennsylvania Department of Health's Rules and Regulations for Ambulatory Care Facilities, Annex A, Title 28, Part IV, Subparts A and F, Chapters 551-573, November 1999.	S 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE: (X6) DATE:

Certified End Page

ASSOCIATES SURGERY CENTERS, L.L.C.

STATE LICENSE NUMBER: 50361501

SURVEY EXIT DATE: 01/04/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY